

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5305 63-036144
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED OCT 9 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1			
2 3 118			
3			
4 0			
5 3			
6			
7 1			
8 1			
9 527.2			
10			
11			
12 57.0			
13			
ITEM NO.	SHOULD READ	MEDICAL CERTIFICATION	BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen Hosp and Med Center		d. STREET ADDRESS (If outside, give location) 1313 Washington	
3. NAME OF DECEASED (Type or print) First Charles Middle Dendy Last Gaines		4. DATE OF DEATH Month 9 Day 25 Year 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-16-17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) South Carolina U.S.A.	
13a. FATHER'S NAME Charles Edgar Gaines		13b. MOTHER'S MAIDEN NAME Alyha O'Neill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Records: K.C., Mo. General Hosp. & Cen	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO (b) Chronic lung disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) _____		14. NAME OF HUSBAND OR WIFE "Unknown" Address _____ Interval between ONSET AND DEATH _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9-9-63 to 9-25-63 and last saw her alive on 9-25-63 Death occurred at 1:35 p on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 2400 Cherry - K.C., Mo.	
22c. DATE SIGNED 9-26-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-7-63	
23c. NAME OF CEMETERY OR CREMATORY National Cem.		23d. LOCATION (City, town, or county) (State) Flt. Leavenworth Mo.	
24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES(S) K.C., MO.		25. DATE RECD. BY LOCAL REG. 10-1-63	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

_____, Student Embalmer No. _____

Student _____

Signed James A. Kippore

Licensed Embalmer No. 5727

P. O. Address 12nd St. N.Y.

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.